Dear Applicant:

Enclosed you will find the forms necessary for you to apply for licensure as an occupational therapist (OT) or occupational therapy assistant (OTA). It is strongly suggested that you read the regulations prior to filling out the application, and then examine the directions entitled **"STEPS TO LICENSURE"** to see which forms are appropriate for you. Please note the following:

(a) Applications not completed in their entirety will be returned, minus the applicable fees, which are non-refundable.
(b) The photograph must be a "passport-style" photo.
(c) The practice history must be current and complete (see enclosed form).
(d) The names on the application and the licensure requirements must be the same or a copy of the legal document(s) effecting the name change(s) must be included with your application. The name on the driver's license or U.S. Social Security Card must be the same as the name on the application. We will not accept nicknames, abbreviations, or alterations.
(e) The home address on the application is the address where this office will mail ALL correspondence. Written notice signed by the applicant is required for an address change.
(f) All checks/money orders for fees are to be made payable to the Mississippi State Department of Health.
(g) The review process regarding an application for licensure starts only after all applicable licensure requirements are on file. The review process is usually completed within two weeks.
(h) Our overnight mail address (see "**OVERNIGHT MAIL**") is as follows:

Mississippi State Department of Health
Professional Licensure - OT/OTA
570 East Woodrow Wilson Blvd.
Jackson, MS 39216

Please be advised that it is illegal for any person to use, in connection with his name or place of business the words "occupational therapist," "licensed occupational therapy assistant," "occupational therapist registered," or the letters "O.T.," "L.O.T.," "O.T.R.," "O.T.A." or "C.O.T.A." or any other words, letters, abbreviations or insignia indicating or implying that he is an occupational therapist or an occupational therapy assistant or to show in any way, orally, in writing, in print or by sign, directly or by implication, or to represent himself as an occupational therapist or an occupational therapy assistant without being currently licensed or specifically exempted by statute and/or regulations.

If you have any questions regarding the above, please contact the licensure office.

Sincerely,

Stephanie Boyette
Health Program Specialist, Sr.

STEPS TO LICENSURE

Applicants may apply for a license in one of the following ways. Please submit the completed, applicable forms as indicated:

1. Regular type license by examination

a. Completed, notarized application;

b. Fees (non-refundable)
   1) Application fee - $100.00; and
   2) License fee - OT - $150.00; OTA - $100.00

c. Verification of NBCOT Certification reported directly to this office from NBCOT;

d. Verification of licensure/registration (current or not current) in any state, territory, province, country, or other jurisdiction reported directly to this office from the licensure/registration authority. (form enclosed, may be copied);

e. Proof of proficiency in the English language, if applicable (see "**ENGLISH PROFICIENCY REQUIREMENTS**");

f. Copy of H1B visa, INS I-94 Form, or other legal document allowing the applicant into the country, if applicable.

2. Limited Permit (per section 4-4(a) of the regulations)

a. Completed, notarized application;

b. Fees (non-refundable);
   1) Application - $100.00; and
   2) License fee - OT - $150.00; COTA - $100.00

c. Verification of education and field work experience reported directly to this office from the institution. The institution must be AOTA-accredited and/or WFOT-approved (form enclosed);

d. Completed Supervision Agreement for Temporary Licensure Applicants Form(s) (form may be copied - 1 page only);

NOTE: This form must be on file and satisfactory to the Branch office before any license may be issued. Once a limited permit is issued, changes in supervision are reported by completing a new form and submitting it to this office prior to the effective date of supervision;

e. Exam for Licensure (see "**NBCOT EXAM**");

f. Verification of any licensure/registration, current or not current, reported directly to this office from the issuing authority (state, province, territory, country, etc.), if applicable. (form enclosed);

g. Proof of proficiency in the English language, if applicable (see "**ENGLISH PROFICIENCY REQUIREMENTS**");

h. Copy of H1B visa, INS I-94 Form or other legal document allowing the applicant into the country, if applicable.

NOTE: Limited permits are available for first-time exam candidates only (see '**NBCOT EXAM**"). An individual must be issued a limited permit prior to beginning to practice according to the supervision agreement (see #2d).

The limited permit licensure period is a maximum of 90 days following issuance. A limited permit is automatically upgraded to a regular type, subject to the regulations. Please refer to section 45 of the regulations for pertinent information regarding this type of limited permit.

A letter of eligibility for a limited permit is available to foreign educated applicants who have met all licensure requirements but do not have a U.S. Social Security Number or the visa documents. This letter should satisfy requirements for the issuance of the INS I-94 Form and the H1B visa.

ENGLISH PROFICIENCY REQUIREMENTS

Foreign educated applicants are required to submit documentation, acceptable to the department, that they are proficient in the English language (see section 43(e)(f) of the enclosed regulations). The minimum acceptable scores needed to meet the licensure requirement are as follows:

A. Test of English as a Foreign Language (TOEFL)
   - Minimum total score of 560;
B. Test of Spoken English (TSE)
   - Minimum total score of 50; and
C. Test of written English (TWE)
   - Minimum score of 4.5.

NOTE: All reports of exam scores must be sent directly to the Department from the examining authority.

Applicants interested in taking the above referenced examinations should contact:

TOEFL/TSF Services
P.O. Box 6151
Princeton, NJ 08541-6151\USA
(609) 951-1100

The code used to request that scores be reported to the Mississippi State Department of Health,

Professional Licensure Branch is -- **9859**.

NBCOT EXAM

The Department recognizes the certification examination of the NBCOT as the licensure exam for Mississippi. Please contact NBCOT or the Professional Examination Service (PES) for exam registration information. It is incumbent upon the applicant for a limited permit to ensure that the appropriate steps are/were taken to complete registration for the exam within the time period allowed for registration. Please plan accordingly.

The next qualifying exam must be taken or the limited permit shall expire when the results of that exam have been reported to the Department. The limited permit, in this case, is not renewable. It is the limited permit holder's responsibility to have the exam score reported to the Department from PES. Any individual issued a limited permit who fails an exam at least two months prior to the expiration date of the limited permit should contact the Branch office expeditiously.

OVERNIGHT MAIL

Overnight mail packages containing an official document that is a licensure requirement must be shipped directly to the Department of Health from the institution or agency office issuing the document. The requirement must have the office's return address on the overnight envelope or the licensure requirement must be sealed in an official envelope of the office within the overnight package. Official documents for licensure forwarded to this office through the applicant or a third party will not be accepted for licensure purposes. Overnight mail should be sent to the:

Mississippi State Department of Health
Professional Licensure - OT
570 East Woodrow Wilson Blvd.
Jackson, MS 39216

Enclosures:

1. Licensure application
2. Verification of Education/Fieldwork
3. Verification of Licensure
4. Supervision Agreement for Temporary Licensure Applicants
5. Verification of NBCOT Certification
6. Practice History form

PRACTICE HISTORY

Instructions: Please list the facility, home health agency, etc., its location (city & state), and the dates that you practiced at that facility in chronological order beginning with your last practice site. A resume' may be attached if the information needed to complete this history is on the resume'. This sheet may be copied if additional space is needed.

FACILITY	LOCATION	DATES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

SUPERVISION AGREEMENT FOR TEMPORARY LICENSURE APPLICANTS

PRINT OR TYPE ONLY

Temporary License Applicant:

_____

name

_____

home address

_____

city state zip

_____

employer name

_____

address

_____

city state zip

Facility/Agency Name, Address and Telephone Number (Once licensed, the applicant may only practice at the facilities/with the home health agencies listed on this form. Additional practice sites may be listed on a sheet of paper and attached to the form.)

1. _____

_____

_____

_____

2. _____

_____

_____

_____

3. _____

_____

_____

_____

Supervisor:

Name: _____

License # _____

Beginning Date of Supervision: ____/____/_____

I hereby certify and affirm, under the penalties of perjury, that the information on this form is correct. I understand that, as an occupational therapist, I may practice only under the supervision of the above named supervisor, or, as an occupational therapy assistant, practice under the above named supervisor in accordance with the supervision provisions for occupational therapy assistants listed in Section X of the *Regulations Governing Licensure of Occupational Therapists and Occupational Therapy Assistants* in the facilities/agencies listed on this form and only after a temporary license is issued to me.

_____

applicant signature date

I hereby certify and affirm, under the penalties of perjury, that the information contained on this form is correct and that I will provide supervision for this applicant at all times when practicing at the listed facilities/agencies. I understand and accept fully that I am responsible for the practice of the applicant once a temporary license has been issued. I agree that I will contact the Professional Licensure Office, in writing, and provide copies to the supervisee and to the administrators of the facilities/agencies listed on this agreement within three (3) days of the termination of this agreement.

_____

supervisor signature date

Upon completion the supervisor should mail this form to the:

Mississippi State Department of Health
Professional Licensure - OT
P.O. Box 1700
Jackson, MS 39215-1700

Occupational Therapist (OT) and
Occupational Therapy Assistant (OTA)

Application for License

(Please type or print in ink)

MISSISSIPPI
STATE DEPARTMENT OF HEALTH

Office Use

Check No._____

Amount $_____

Date ____/____/____

License Type

OT ☐
OTA ☐

Limited Permit *(if applicable)* ☐

Personal

Name: _____
(Last) *(First)* *(Middle)*

Home Address: _____
(Street)

_____ Telephone Number (_____)_____
(City) *(State)* *(Zip Code)* *(County)*

U.S. Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth: ☐☐ - ☐☐ - ☐☐

Race:_____ Sex: Male ☐ Female ☐ U.S. Citizen: No ☐ Yes ☐ Legal Alien: No ☐ Yes ☐ Visa Type & No.:_____

Professional

Employer: _____

Business Address:_____

_____ Telephone Number (_____)_____
(City) *(State)* *(Zip Code)* *(County)*

Practice Type

Insert # _____

1. Patient Care
2. Administration
3. Teaching
4. Research
5. Other Activity
6. Not Active in OT

Practice Setting

Insert Primary # _____ Secondary #_____

1. >100 Bed Hospital
2. <100 Bed Hospital
3. Nursing Home
4. Home Health
5. Physician's Office
6. School
7. Private Practice
8. Outpatient Facility
9. Other
10. Not Applicable

Education

Limited Permit Applicants: Verification of Education form must be submitted directly from the institution.

School _____
(Name) *(City)* *(State)* *(Country)*

Type of Degree _____ Date_____

Licensure

Have you ever been licensed or registered in any state, territory or country? No ☐ Yes ☐ If yes, list all licenses (current/not current) including Mississippi. ***All licenses/registration must be verified by the jurisdiction - with board seal. (See Verification of Licensure Form.)***

1. _____ 4. _____ 7. _____ 10._____
2. _____ 5. _____ 8. _____ 11._____
3. _____ 6. _____ 9. _____ 12._____

Licensure *(continued)*

Have you ever had a license or permit encumbered in any way, i.e., revoked, suspended, rejected, placed on probation, etc? *All action must be reported by the jurisdiction with the verification of license/registration.* No ☐ Yes ☐

Are there any criminal or civil suits pending against you? No ☐ Yes ☐

Have you ever been convicted of any violations of law (except minor traffic violations)? No ☐ Yes ☐

Have you ever been convicted of a felony related to the practice of Occupational Therapy? No ☐ Yes ☐

Certification **(See "Steps to Licensure")**

Are you certified by NBCOT? No ☐ Yes ☐

- If yes, verification of current certification must be reported directly from NBCOT.
- If no, list the date of the first exam you will be eligible for _____ (Month) / _____ (Year) .

Occupational Status

Attach completed Practice History form.

Fees

Fees enclosed: $100.00 Application (non-refundable)

_____ License OT $150.00

_____ License OTA $100.00

_____ **Total**

Make check or money order payable to:
Mississippi State Department of Health

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Occupational Therapists and Occupational Therapy Assistants and affirm that all conditions for licensure have been met and will be maintained.

_____
(Applicant's Signature)

Complete form, enclose fee and mail to:
Mississippi State Department of Health
Professional Licensure: OT/OTA
P. O. Box 1700
Jackson, Mississippi 39215-1700

Attach Copy
of Driver's License
or
U.S. Social Security Card

Attach Photo

Subscribed and sworn to before me this _____ day

of _____, 19 _____.

My commission expires _____.

_____
(Notary Public)

Occupational Therapist and Occupational Therapy Assistant

Verification of License in Another State

To be Completed by Applicant *(Please print or type)* Social Security No.:_____-_____-_____

Name:_____

Licensing Authority:_____ Number:_____ Date Issued: _____
(State, Territory, or Country)

_____
(Applicant Signature)

To be Completed by Secretary of Licensing Board

Licensee's Name: _____

License Type (OT/OTA): _____

License Number: _____

Date Issued: _____

Expiration Date: _____

Licensed By: NBCOT Certification: _____

Reciprocity with: _____

Other: _____

Has license ever been disciplined? ☐ No ☐ Yes *(if yes, please attach findings and disposition.)*

Remarks: _____

_____

_____

Licensing Board must return to:
Mississippi State Department of Health
Professional Licensure: Occupational Therapy
Post Office Box 1700
Jackson, Mississippi 39215-1700

_____
(Authorized Signature)

This document must show Seal of licensing agency.

Seal

Verification Of Education For Licensure In Occupational Therapy

Instruction To Applicant:

Upon completion of the demographic information and waiver below, this form should be signed, notarized, and forwarded to the college or university where you obtained your degree in Occupational Therapy.

Name (Last, First, Middle Initial)	*Maiden Name or Given Surname*
Address (Street, City, State and Zip Code)	*Phone No.* *Home* ( ) *Work* ( )
Social Security Number	*Date of Graduation*
License Applying For (Check One): ☐ Occupational Therapist (OT)	☐ Occupational Therapy Assistant (OTA)

Waiver For The Release Of Information:

I am applying for licensure as an OT/OTA in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure – Occupational Therapy, should this information be requested at any time.

Subscribed and sworn to before me this day of_____19____

My commission expires_____19_____.

_____
Notary Public

Seal

_____ _____
Date *Signed*

Instructions To Educational Institution:

Upon completion of this form please send directly to:

Mississippi State Department of Health
Professional Licensure - Occupational Therapy
P.O. Box 1700
Jackson, MS 39215-1700

Name of Institution	*Location of Institution (City&State)*
Dates of Attendance (Month/Year) From: To:	Has applicant successfully completed all academic requirements and field work requirements? ☐ No ☐ Yes, date _____
Date Degree Conferred	*Degree Conferred*
Program Name & Curriculum Description	*Practicum/Internship* From: Month_____ Day_____ Year_____ To: Month_____ Day_____ Year_____ Total Number of Weeks:

Occupational Therapist/Occupational Therapy Assistant Program Accreditation *(on date degree conferred)*

OT Program Accredited by AOTA	☐ No	☐ Yes	OT Program accredited by WFOT	☐ No	☐ Yes
OTA Program Accredited by AOTA	☐ No	☐ Yes	OTA Program Accredited by WFOT	☐ No	☐ Yes

Seal of the College or University

_____
Signature

_____
Title

_____
Telephone Number *Date*

COMMON QUESTIONS REGARDING NBCOT VERIFICATION OF CERTIFICATION TO STATE BOARDS AND OTHER AGENCIES

Who is NBCOT?

The National Board for Certification in Occupational Therapy, Inc. (NBCOT) is the independent national credentialing agency that certifies persons as an OCCUPATIONAL THERAPIST REGISTERED OTR® or as a CERTIFIED OCCUPATIONAL THERAPY ASSISTANT COTA®.

Score Information

If a state or other agency is asking for your **score report**, you will need to place your order with our testing agency, **Professional Examination Service (PES).** You may call our office (301) 990-7979 and ask to be placed in the score information voice box, or you may obtain an order form on our web site: www.nbcot.org. NBCOT **does not** report scores. It is in your best interest to contact the board in the state in which you are applying for licensure to see which service it requires. You should ask: "Do I need a score report or a verification letter?"
******Please note, if you were certified prior to **1985**, your score information cannot be reported**. ****

NBCOT Verification of Certification Request Form

Verification Fee and Processing Information

The fee for **each** verification letter request is **$30.00**. NBCOT will accept a personal check, money order, or credit card payment -Visa or MasterCard. Requests submitted without the required fee will be returned. There is a $30.00 fee for any returned check.
Verification fees are non-refundable. Please allow **2** weeks for your request to be processed and mailed.

Where should I send my request?

♦Credit Card payments via fax: If you are paying by credit card, you may fax this form to: (301) 869-8492. Our fax machine is available 7 days a week, 24 hours a day. You are faxing to a secure location.

♦Personal Check, Money Order, Credit Card, non-fax: Please mail your request to our bank lock box, ***not*** our street address.
Submit your request to:
NBCOT, Inc.
Attn: Verification Letter
P.O. Box 64971
Baltimore, MD 21264-4971

¨ **NO PHONE ORDERS OF ANY TYPE ARE ACCEPTED**¨

♦ Can I provide an overnight envelope to a state board?

♦**YES**. If you wish to provide a **pre-paid, addressed, overnight/2-day** (Fed-Ex, UPS, Express, Priority) envelope to a state board or agency, please send your request to our street address:

NBCOT, Inc.
Attn: Verification Letter
800 South Frederick Ave
Suite 200
Gaithersburg, MD 20877

The name on my NBCOT record

If your name is different from what our certification records reflect, and you want the verification notice processed in your new name, the NBCOT requires legal documentation of the name change (i.e., marriage license, divorce decree, or court order). Submit an original certified copy or a notarized photocopy (i.e., copy the document and have it notarized) to reflect your change in name. Please attach your name change documentation to your verification request.

♦If you are submitting a name change, you must ***mail*** your entire request (name change documents, fees, and this form) to the *Baltimore, MD address.* Faxed requests can **NOT** be honored.♦

♦ **NBCOT VERIFICATION OF CERTIFICATION REQUEST FORM** ♦ **Side 2 of 2**

To request a letter verifying your NBCOT certification, complete this form. Please **print** or **type** your request. The letter NBCOT produces will include; your name, your certification number, the day- month-year you were certified, the day-month-year you are certified through (renewal date), your status as either an OTR or COTA, and a disciplinary comment**. REMINDER: THIS LETTER IS PROCESSED ONLY IF YOU HAVE TAKEN AND PASSED THE CERTIFICATION EXAMINATION.**

Please check one- I have: **A)** Faxed my verification request _____ **B)** Mailed my verification request_____

* If you have faxed your request, please allow ample processing time (one week) to verify receipt of your request.

_____
♦FULL NAME

_____
♦STREET ADDRESS-

Please check if address is new _____

_____
♦CITY, STATE, ZIP CODE, COUNTRY

_____
♦SOCIAL SECURTIY NUMBER

_____
♦DATE OF BIRTH (Month/ Day / Year)

_____
♦CERTIFICATION NUMBER

♦CIRCLE ONE: **OTR** OR **COTA**

_____
♦HOME AREA CODE/PHONE NUMBER

_____
♦DAYTIME AREA CODE/PHONE NUMBER

♦STATE BOARD, EMPLOYER OR AGENCY TO SUBMIT VERIFICATION REQUEST. (If 2 or more state boards, please abbreviate – i.e. MD & VA)

_____

_____

_____

ADDITIONAL INFORMATION

1. Please ***do not*** enclose a self addressed stamped envelope (.34 cent SASE) to your state board.

2. Verification letters ***cannot*** be faxed.

3. Please check here if you are taking or have taken the certification exam in **2002**.

Winter 2002 Examination _____

Spring 2002 Examination _____

4. Please check here if you have enclosed name change documentation.

Name change documentation enclosed _____

If I have enclosed name change documentation and would like my notarized/certified documents returned, I have enclosed a Self-Addressed Stamped Envelope (SASE). _____

METHOD OF PAYMENT: - $ 30.00 per letter

A) Visa _____ MasterCard_____

Credit Card Number:

_____

Expiration Date: Month ____ Year____

Amount of Credit Card Charge: _____

Signature - Required for Credit Card Requests

_____

B) Check _____ Money Order_____

Verification Letter Order Date _____

QUESTIONS REGARDING MY VERIFICATION REQUEST

Please feel free to contact the NBCOT directly:
301-990-7979 X3131 or via e-mail: verify@nbcot.org